

Emergency Action Plan Period _____ to _____ Review Date _____	EMERGENCY ACTION PLAN
I. IDENTIFYING INFORMATION	
Student Name	Birthdate
Primary Physician	Phone
Specialist Physician	Phone
Preferred Hospital	Allergies
II. STUDENT SPECIFIC INFORMATION	
If you see this . . .	Do this . . .
IF AN EMERGENCY OCCURS	
<ol style="list-style-type: none"> 1. Stay with the student or designate another adult to do so. 2. Call or designate someone to call the school nurse and/or principal or building administrator. <ol style="list-style-type: none"> a. State who you are. b. Where you are located (school, location in building). c. Nature of the problem. 3. The nurse will assess the child and determine whether the emergency plan should be implemented. 4. If the nurse is unavailable, the following staff members are trained to deal with this emergency, and to initiate the emergency plan. If situation appears to be life-threatening, call 911. 	
Staff Member(s)	Location